

Clinical Section

Coccygodynia

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The name Coccygodynia, which was applied to the condition of persistent pain in the neighborhood of the coccyx by Simpson, in 1859, has caused much speculation as to the cause and treatment of this often distressing and intractable condition.

My attention was drawn to Thiele's new theory as to the cause of Coccygodynia and its treatment, which he brought forward in a paper read at the American Proctological Society in 1936.

Thiele was first to observe that cases of Coccygodynia were associated with spasm of the pelvic muscles, the levator and/or coccygeus muscles.

In those patients in whom there was pain radiating to the gluteal region of the hip or down the back of the leg, tonic spasm of the piriformis muscle was found. When the pain was present in the leg, it occurred in the left leg without exception. Pain in the right leg did not occur alone. These facts may be coincidental.

Seventeen cases were collected during the last five years:

1. Sex13 Females4 Males
2. Age25-52 yearsAverage 42.8
3. Duration of symptomsAverage 8-14 months
4. Trauma1 following Parturition16 Idiopathic
5. Post-operative:

6 had hemorrhoidectomies before the onset of symptoms.
6. Site of pain:

2 confined to coccyx.

5 confined to supragluteal region or down back of thigh.

10 Coccygodynia combined with pain in the supragluteal region or down back of thigh.

Clinical Histories

The histories of cases seen is fairly typical. The first symptom is a sense of weight or heaviness that is referred to the rectum. This gradually increases in severity to the point where there is pain of such a severe aching character that the patient seeks relief. This pain is referred to the region of the coccyx, and is aggravated by sitting on a hard chair or by the act of sitting down or arising. Lying down flat on the

back also causes an aggravation of the pain. In a certain number of cases another symptom is that of pain down the posterior part of the thigh, which varies from a mild ache to the most severe boring aching pain.

Patients walk somewhat stiffly and sit down cautiously, generally on one buttock, and often close to the edge of the chair.

The diagnosis of Coccygodynia rests on the findings during a rectal examination. With the patient in Sim's position, and the finger in the rectum palpating in the latero-posterior quadrant, the "spastic levator ani and coccygeus" muscles are easily felt, stretching from their origin (at the arcus tendineus or ischial spine) to the side of the coccyx or lower part of the sacrum.

The piriformis muscle is felt with the tip of the finger just distal to the sacrospinus ligament and lateral to the 2nd, 3rd, and 4th sacral vertebrae. It is more easily felt on the right side when the patient is lying on the left side, and vice versa. Spasm of the piriformis is sometimes very difficult to ascertain with certainty, owing to the fact that the muscle is so far from the anus that its palpation is difficult.

The piriformis muscle can be identified by its "increasing size" during external rotation of the extended thigh.

Freiberg's sign of piriformis spasm is often positive. It is evidenced by limitation of inward rotation of the fully extended thigh.

Another physical finding is tenderness of the muscles involved.

Tenderness of this group of muscles is unmistakable when present, the slightest pressure with the finger provoking cries of pain.

Tenderness from bidigital pressure on the coccyx itself is not marked, and may even be absent.

Movement of the sacrococcygeal joint is often productive of severe pain, but cases have been observed in which, although the joint could be moved painlessly, nevertheless the levator ani and the coccygeus muscles were extremely tender.

Tenderness of the sciatic nerve is demonstrated in the usual manner by external pressure, but is more pronounced when pressure on the nerve is made from within the pelvis.

Mode of Production of Pain

First of all one must remember that muscle spasm itself is very painful.

Spasm of both portions of the levator ani exerts forward as well as lateral traction on the coccyx.

Contraction of both coccygei exerts forward traction on the coccyx. Unilateral contraction of the coccygeus exerts traction which is more nearly lateral. Thus it may be seen that in the presence of arthritis or trauma of the sacro-coccygeal articulation, spasm of either of these muscles would tend to increase the pain in the joint — Vicious circle: i.e., pain, spasm, more pain and more spasm.

Chronic spasm of the coccygeus which has the same attachments as the sacrospinous ligament may, through long-continued action, shorten the distance between the lateral sacro-coccygeal border and the spine of the ischium, thus affording opportunity for shortening of the sacrospinous ligament. Whether this actually occurs is problematical.

As has been stated, in patients who complained of pain in the supragluteal region with or without pain down the back of the thighs, the pelvic portion of the piriformis muscle on the affected side was more tender to pressure and its belly firmer to the touch than on the unaffected side.

The piriformis muscle arises from between the first four sacral foramina and also from the grooves leading from the foramina. A few fibers also arise from the anterior surface of the sacrotuberous ligament. If one considers the sacrum as the origin of the piriformis, then some of its lower fibers insert into the inferolateral margin of the great sacrosciatic foramen instead of arising there as stated in numerous textbooks on anatomy. This insertion into the inferolateral margin of the great foramen provides an efficient mechanism whereby contraction of the piriformis may squeeze the sciatic nerve against the lower border of the foramen formed by the sharp edge of the sacrospinous ligament and the upper borders of the gemellus superior and coccygeus muscle.

The piriformis passes out of the pelvis through the greater sacrosciatic foramen and is inserted by a rounded tendon into the inner side of the upper border of greater trochanter—at its upper border it is in apposition with gluteus medius muscle, gluteal vessels and supragluteal nerve.

It is not difficult to visualize that spasm of the piriformis could cause pressure on the sciatic nerve, particularly in the presence of a spastic coccygeus muscle with or without a shortened sacrospinous ligament.

In a like manner it may also squeeze the supragluteal nerve by pressure against the lower border of the gluteal medius.

One must also remember that in about 10% of cadavers, the sciatic nerve instead of passing below the piriformis, perforates its belly before passing through the greater sciatic foramen.

Freiberg calls attention to the fact that the piriformis is the only muscle which bridges the sacro-iliac joint and that spasm of this muscle may result from sacro-iliac disease or trauma. Thiele thinks that it is therefore reasonable to assume that we might have spasm of the levator ani and coccygeus secondary to the pelvic imbalance resulting from sacro-iliac disease, through its effect on the piriformis muscle and sacro-tuberous ligament, i.e., sacrosciatic pain or trauma—piriformis spasm—levator and coccygeus spasm, and finally ano-rectal pain or coccygodymia.

How are we to explain that the cause of the spasm of these muscles is the result of disease found in the anus and rectum?

It is quite believable that anorectal disease gives rise to levator and coccygeus spasm which will cause pelvic imbalance and thereby cause piriformis spasm and finally sacrosciatic pain.

Treatment

Spasm of the muscles in question is relieved by massage.

The patient is placed in the Sim's position and the index finger is introduced into the rectum. Lateroposterior pressure will place its flexor surface horizontally across the surface of the levator ani and coccygeus muscles almost at a right angle to their fibers.

The fibers of the piriformis muscle are felt immediately beyond the sacro-spinous ligament, and are touched by the finger tip in such a manner that lateral motion of the finger will stroke lengthwise that portion of the belly of muscle lying within the pelvis.

These muscles are massaged in the long direction of their fibres in the same manner that a strop is stroked by a razor.

Massage is begun lightly and is performed three times per week. As the spasm and tenderness of the involved muscles decrease, greater pressure is applied on the muscles.

As the result of their first treatment by massage, there is an immediate improvement in the majority of cases, and the patients are grateful for the relief obtained.

The Layman's Interest in Post Mortems

From "A Broader View of Postmortem Examinations" by Alan Gregg, New York, N.Y.

Ann. Int. Med. 1938, 12 p. 249

I saw by chance a blackboard lying on its side in apparent neglect. On it were written the percentages for the preceding quarter of post-mortem examinations secured on deaths (a) on the private wards and (b) on the public wards; 13 per cent of the private patients who died came to post mortem; 82 per cent of the patients on the public wards came to post mortem. Quite appropriately that table of figures on post mortems was lying on its side, for it bore evidence of neglect of one of the most enlightening and stimulating practices we physicians know—the postmortem examination. We know the post mortem can and does improve our efforts at diagnosis, we know it is the terror of the casual guesser, we know it is a reward to an eager and honest doctor even when it is a stark corrective, we know it increases our competence and knowledge—in sum, we know the post mortem serves as a merciless incentive to the best we have in us as physicians.

But does the layman know? Let me draw these three experiences together now in the question I wish to ask you: Shall the layman be told this incentive to our best performance? Is it not true that if a layman wishes to get the best possible service from a physician he would be wise to say at the outset of an illness—"Now Doctor, there's one thing I should like to have clear: if worse comes to worst there is to be a post mortem"?

In increasing measure the American of all classes uses a hospital. We know that he would be wise to demand rather than reluctantly concede the performance of a postmortem examination. But does he know it? I doubt it. And is it wise for him and for us that he should remain any longer uninformed of a safeguard within his reach?

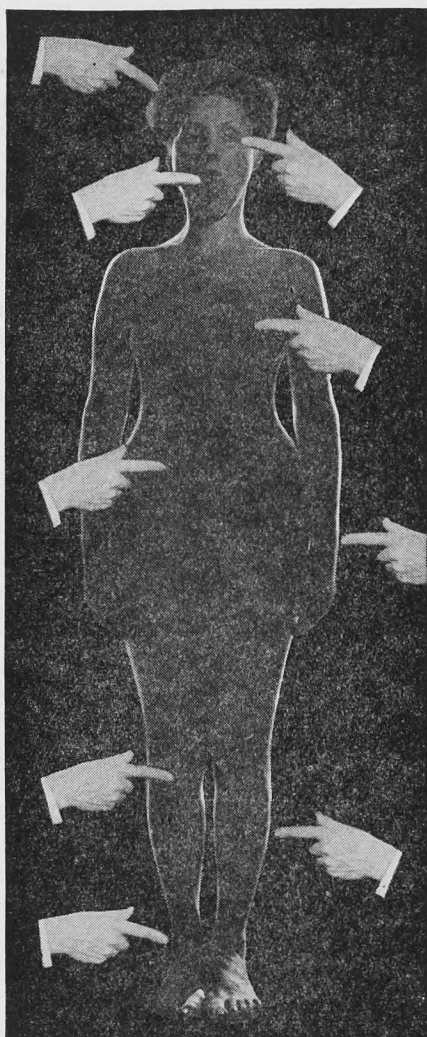
I have never heard the layman's interest mentioned in discussions of post mortems. The postmortem examination has been emphasized as a way to advance scientific knowledge, or it has been thought of as a generous concession to the forgivable curiosity of a beloved doctor, or it has been urged as a method without equal in maintaining staff efficiency in hospitals—but I would inquire whether anyone unprejudiced and remote from the event has ever shown the laity where its interests lie in the matter of post mortems? Is it reasonable to tell the layman that the warning of a post mortem might urge and convert an incompetent doctor in time from proud isolation to prudent consultation? Is it reasonable to say that the mention of a post mortem would never lessen the interest of a competent and trustworthy doctor? Is it

reasonable to state quite candidly that in the request for post mortems the public has a means of protecting its own interests? To have an understanding with a physician that if death comes an autopsy will follow involves, as it seems to me, no extra risk whatever to the patient.

The question perhaps suggests that two assumptions are being taken for granted: one that there are no great objections in the lay mind to post mortems, and the other that there are enough competent pathologists ready for such a revolutionary change. Neither of these assumptions is true at present, but both are capable of becoming true gradually and at a rate that will not jeopardize the change. Both were even more valid objections when hospitals began to secure post mortems. If, as the phrase goes, "no effort is to be spared to improve the patient's chances" is it not time to have it widely known that experience shows that the practice of post mortems has improved the patient's chances?

There is real need for each profession to teach the laity how best to use its services. In America where with increasing frequency doctors' services are called in ignorance of their capacities, the ways of protecting the laity are of importance. Among other means too numerous to mention at this time one simple suggestion is then here offered for your comment: the performance of postmortem examinations, in that it has greatly improved our efforts as doctors, should be known by the laity as an advantage also within their power to demand.

So the essential point is this: do you endorse my view that one simple but powerful piece of advice in his own protection the layman could wisely be given is this—"Explain to whomever you call that if death comes a post mortem will be required"? It may be grim advice—but in the cause of good medicine we do not shirk giving grim advice. It may not be heeded—we have had that experience too. But it can be understood—and because it is in the interest of the patient, the post mortem can change gradually from being hated and feared and avoided to being used and trusted and steadily perfected. We have known similar transitions in the past. Already, as many of you know, the clinicopathological conference is the wonder and admiration of many of our foreign visitors, who see in it a candor and fearlessness altogether to the credit of American medicine.



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Personal Notes and Social News

Dr. J. G. Medway is now practicing at Kenton, Man.

◆ ◆

Dr. M. R. Hodgson is now located at Steinbach, Man.

◆ ◆

Dr. I. H. Mazerovsky has taken up practice at Churchill, Man.

◆ ◆

Dr. Geo. Consell is resident physician at Victoria Beach, Man.

◆ ◆

Dr. T. F. Waugh will be resident physician at Grand Beach, Man.

◆ ◆

Dr. W. G. Glassco is now on the staff of the Brandon Mental Hospital.

◆ ◆

Dr. W. G. Newman is now located with the Abbott clinic in Winnipeg.

◆ ◆

Dr. P. D. Hooze has moved from Steinbach, Man., to Kindersley, Sask.

◆ ◆

Dr. Gladys Nitikman has left to take up a position at the Royal Victoria Hospital, Montreal.

◆ ◆

Dr. Sara Dubo is now working on a fellowship in the Department of Pathology, University of Toronto.

◆ ◆

Dr. David Swartz has joined the R.C.A.M.C. with the rank of Captain. At present he is located at M.D. 10.

◆ ◆

Dr. Edgar M. Gee has enlisted as a surgeon-lieutenant for active naval service and has left for the East Coast.

◆ ◆

Dr. Louis Kobrinsky and his wife, formerly Dr. Bella Kowalson, have moved from Preeceville, Sask., to Winnipeg.

◆ ◆

Dr. T. H. Cuddy has returned from Atlantic City, where he attended the American Medical Association Convention.

◆ ◆

Dr. A. B. McCarten has enlisted with the R.C.N.V.R. as a surgeon-lieutenant. He will be stationed at the East Coast.

◆ ◆

Dr. Clifford L. Comrie "42" has enlisted with the R.C.A.M.C. as a Lieutenant. He is going to Camp Borden to qualify for Captain's rank.

◆ ◆

Dr. and Mrs. Marvin Brandt of The Pas, Man., are receiving congratulations on the birth of a daughter (Patricia Lynn) on May 29th.

Dr. D. J. Fraser, of Souris, Man., has been appointed chief medical officer of the Workmen's Compensation Board, succeeding the late Dr. A. J. Fraser.

◆ ◆

Dr. Ida Armstrong was chosen Manitoba vice-president of the Federation of Medical Women of Canada at the annual meeting at Jasper, Alta.

◆ ◆

Congratulations are being received by Doctor and Mrs. Kenneth C. McGibbon on the birth of a son (David Breen) at the Misericordia Hospital, June 21st.

◆ ◆

Dr. I. O. Fryer has been appointed a coroner for Manitoba. He will act as assistant to Dr. R. W. Gorrell and will preside at inquests in the Winnipeg district when Dr. Gorrell is unavoidably absent.

◆ ◆

Lieut-Commander C. W. McCharles, R.C.N. V.R., now stationed on the West Coast, attended the Canadian Medical Association Convention at Jasper and enjoyed meeting his many acquaintances from Winnipeg.

◆ ◆

Dr. J. Ross Kelly of Brandon, Man., was married June 10th, in Dauphin, to Miss Nora Irene McFadden, second daughter of Mr. and Mrs. J. N. McFadden of Dauphin. Dr. Kelly is the son of Mr. and Mrs. W. J. Kelly of Edmonton, Alta.

◆ ◆

Captain Carl C. Henneberg was married April 18th to Nursing Sister Kathleen Martha Warham, at Taplow, Berks, Eng. Dr. Henneberg is a graduate of the Manitoba Medical College. Mrs. Henneberg was attached to No. 5 General Hospital Nursing Unit.

◆ ◆

The executive and members of this association wish to express their deepest sympathy to Dr. and Mrs. W. Creighton in the loss of their son, Pilot Officer John T. Creighton, who was accidentally killed while on an operational flight near Debert, N.S., Sunday, June 7th.

◆ ◆

Doctor T. A. Pincock has been appointed provincial psychiatrist to succeed Doctor A. T. Mathers, who resigned. Doctor Pincock will assume his new duties August 1st. Dr. Brian Bird, assistant physician at Brandon Mental Hospital has been appointed acting assistant medical superintendent in the psychopathic hospital at Winnipeg.

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Canadian Medical Association Convention at Jasper

The 1942 Convention of the Canadian Medical Association at Jasper June 15th to 19th was memorable in several respects. The beauty of the mountain scenery, the accessibility of the golf course and other holiday pursuits and the excellent quarters and cuisine made a thoroughly enjoyable combination. The fact that most of the 575 doctors who attended were able to live in close proximity at the lodge instead of being scattered over a large city, helped greatly in promoting social and professional contacts.

The General Council of the Canadian Medical Association passed in principle the idea of Health Insurance based on the 18 points, somewhat amended. Some knotty problems such as section 12 and the question of teaching material were left to provincial regulating boards. The government is giving five seats on the Procurement and Assignment Board for medical personnel in the armed forces to Canadian Medical Association appointees.

Most of the scientific papers were of a high order. Many who came to listen to certain papers with dismal titles found stimulation, wit, and new ideas instead of boredom.

At one luncheon meeting a question and answer period was very popular. Written questions were sent up to the head table to be answered impromptu by a panel of specialists, including Dr. Alan Brown, Dr. Duncan Graham, Dr. G. S.

Fahrni, Dr. Paul O'Leary of Mayo's, and Dr. J. D. McQueen.

The following Manitoba doctors presented papers or lead discussions: D. C. Aikenhead, Ross Mitchell, J. D. McQueen, P. H. T. Thorlakson, J. D. Adamson, O. J. Day, M. R. McCharles, C. W. Burns, A. R. Birt, F. G. Allison, F. D. McKenty, Gordon Chown, Harry Medovy, H. D. Morse.

Quite a number of Manitoba men attended the convention.

Doctor G. S. Fahrni gave the Presidential Address: "Medicine and the Nation." He touched on many topics, but health insurance was his major theme. The Gallup Poll has shown that 75% of Canadians are in favor of health insurance. Doctor Fahrni saw two reasons for bringing in a comprehensive health plan before the war ends: the sense of security it would give the population during post-war reconstruction, and the wisdom of coming to an agreement now, before our government becomes too bureaucratic.

On Preparing Hypodermic Injections

When leaving on a call for which a hypo may be needed, it may save time to request the relatives by telephone to put an inch or two of water on to boil in a small saucepan.

To prepare the injection drop the hypo tablet into the barrel of the syringe, put in the plunger until it nearly touches the tablet, attach and test the needle, tie a piece of string around the barrel of the syringe and immerse the syringe in the boiling water for two minutes. Leave the end of the string hanging over the side of the saucepan so that the syringe may be lifted out aseptically and painlessly. Some of the boiled water may be sucked up in the syringe as soon as it is cool enough to handle, and the injection is ready.

This method is simple, speedy and sterile. It avoids open flames, spoons or unsterile syringes kept in alcohol.

District Society Notes

Northwestern Medical Society

The North Western Medical Society held its second meeting of the year at Virden, on June 10th. The speakers were Doctors W. F. Abbott and H. E. Popham.

Doctor Abbott spoke on, "Cystocele and Prolapse of the Uterus." His approach to the sub-

ject was somewhat new to most of the audience and was made interesting and profitable. Doctor Popham spoke on, "Some of the Commoner Problems in Infant Feeding." He was definite in his statements and was followed with great interest.

The members of the Society are always grateful to those speakers who are good enough to come to these meetings to give of their knowledge and experience.

The ladies were entertained at the home of Mrs. O. S. Ross. All met at supper at the Central Hotel where a jolly time was spent.

The Secretary, Doctor E. D. Hudson, Hamiota, was not present, as he had started that day for Jasper, Alberta, to attend the Canadian Medical Association meeting, where he will receive his Senior Membership in that Association.



The Portage and District meeting (Central District Society) was held at Portage on May 6th.

Doctor F. G. McGuinness spoke on "The Early Recognition of the Onset of Toxaemia in Pregnancy." Doctor Gordon Chown gave a practical demonstration and talked on, "Some Aspects of Infant Feeding."

Doctor G. S. Fahrni, President of the Canadian Medical Association and Doctor H. D. Kitchen, President of the Manitoba Medical Association were also present, and spoke on medical problems, dealing particularly with health insurance.

Brandon and District Medical Society

The Brandon and District Medical Society held a meeting on May 6th.

The speakers were Doctors Chas. Hunter and Doctor Neil J. Maclean. Doctor Hunter spoke on "Common Errors in Medical Practice." Doctor N. J. Maclean spoke on "Some Phases of Appendicitis."

Winnipeg Medical Society

The Winnipeg Medical Society held their Annual Meeting on May 15th in the Physiology Lecture Theatre of the Medical College.

Doctor J. C. Hossack, President, was the speaker for the evening, the title of his paper being, "I Swear by Apollo."

The following Officers for the year 1942-43 were elected:

President—Doctor C. B. Stewart.

Vice-President—Doctor C. M. Strong.

Secretary—Doctor H. F. Cameron.

Treasurer—Doctor D. Swartz.

Trustee—Doctor J. E. Tisdale.

Manitoba Medical Association

The Annual Meeting of the Manitoba Medical Association will be held in the Fort Garry Hotel on September 23rd, 24th and 25th.

A team composed of the Canadian Medical Association President, Doctor A. E. Archer of Lamont, Alberta; Doctor W. F. Gillespie, and Doctor John Scott, of Edmonton, accompanied by the General Secretary, Doctor T. C. Routley will be here.

Manitoba Health Officers' Association

The President of the Manitoba Health Officers' Association, Doctor George Clingan, advises that it has been decided to hold the first annual meeting of the Association on Tuesday, September 22nd, the day before the opening of the annual meeting of the Manitoba Medical Association.

There will be further information later and each Health Officer in the Province will receive a personal notice. There will be a very much worth-while programme.

W. K. Kellogg Foundation Donates \$10,000 for Student Loans

Ten thousand American dollars have been donated to the Manitoba Medical College by the W. K. Kellogg Foundation of Battle Creek, Michigan. Dean Mathers announced that it will be used as a loan fund to assist medical students whose new seven-week summer holiday is not long enough to earn enough money to carry on. Fourth and fifth years are largely taken care of by being allowed to enlist in the army and drawing a private's pay during the final years at college. Five per cent interest will be charged dating from one year after graduation. During war-time the provincial and dominion governments have also agreed to loan money to students on a dollar-for-dollar basis.

Frank W. Horner, Limited, Gift for Clinical Research

A year ago Frank W. Horner, Limited, Pharmaceutical Manufacturers of Montreal, donated \$600 to the Manitoba Medical College. It was decided to use this gift in the Department of Medicine for Clinical Research. Some of the money was used last year in the study of the effect of operative procedures on blood pressure conducted by Dr. Sarah Dubo.

Department of Health and Public Welfare

COMMUNICABLE DISEASE REPORT

April 23—May 20, 1942

MEASLES: Total 615—Winnipeg 352, St. Boniface 64, Brandon 45, Portage la Prairie City 20, Emerson Town 19, Daly 10, St. Paul East 9, Kildonan West 7, Oakland 7, St. Vital 6, Bifrost 5, Montcalm 5, Kildonan East 4, Swan River Town 4, Beausejour 3, St. James 3, Tuxedo 3, Unorganized 3, Flin Flon 2, Ritchot 2, Tache 2, Brokenhead 1, Brooklands Village 1, Hamiota Village 1, Hanover 1, Kildonan North 1, Miniota 1, Minnedosa Town 1, Morris Rural 1, Pipestone 1, Portage la Prairie Rural 1, Ste. Anne 1, St. Clements 1, Whitehead 1, Whitewater 1. (Late Reported: Miniota 7, Neepawa Town 5, St. Boniface 3, Brandon 2, Portage la Prairie City 2, Piney 1, Emerson Town 1, Rockwood 1, St. Vital 1, Woodlands 1, Woodworth 1, Unorganized 1).

MUMPS: Total 358—Winnipeg 107, Brandon 59, Portage la Prairie City 52, Transcona Town 30, St. Boniface 25, Tuxedo Town 22, St. James 11, Selkirk 7, Unorganized 4, Fort Garry 3, Minnedosa Town 3, Pipestone 3, Daly 2, Emerson Town 2, Hamiota Rural 2, Hamiota Village 2, Kildonan East 2, Portage la Prairie Rural 2, Sifton 2, Virden Town 2, Whitehead 2, Arthur 1, Bifrost 1, Kildonan West 1, Lansdowne 1, Ritchot 1, Rivers Town 1, Souris Town 1, St. Vital 1. (Late Reported: Portage la Prairie City 2, Brandon 1, Brooklands Village 1, St. James 1, Tuxedo 1.)

CHICKENPOX: Total 131—Winnipeg 80, St. Boniface 13, Unorganized 11, Kildonan East 6, The Pas Town 3, Daly 2, Flin Flon 2, Brooklands Village 1, Ethelbert 1, Fort Garry 1, Lac du Bonnet 1, Lansdowne 1, Melita Town 1, Norfolk North 1, Portage la Prairie Rural 1, Rivers Town 1, Tuxedo 1, St. James 1. (Late Reported: Brooklands Village 1, Ethelbert 1, Unorganized 1).

SCARLET FEVER: Total 129—Winnipeg 64, Brandon 21, Tuxedo Town 7, Portage la Prairie City 4, Cornwallis 3, Flin Flon 3, St. James 3, Blanchard 2, Neepawa Town 2, Portage la Prairie Rural 2, Saskatchewan 2, Souris Town 2, Emerson Town 1, Fort Garry 1, Harrison 1, Miniota 1, Roblin Rural 1, Roblin Village 1, Springfield 1, Transcona Town 1, Wallace 1. (Late Reported: Miniota 3, Portage la Prairie City 1, Shell River 1).

TUBERCULOSIS: Total 52—Winnipeg 13, Unorganized 8, Portage la Prairie City 7, Wallace 4, Brandon 2, Ritchot 2, St. Vital 2, Cypress North 1, Dauphin Town 1, DeSalaberry 1, Kildonan East 1, Lac du Bonnet 1, Lakeview 1, Norfolk South 1, Portage la Prairie Rural 1, Rosburn Rural 1, Rosser 1, Shoal Lake Rural 1, Siglunes 1, St. Clements 1, The Pas 1.

GERMAN MEASLES: Total 28—Pipestone 5, Portage la Prairie City 4, Tuxedo Town 4, Brandon 3, Hamiota Rural 3, Fort Garry 2, Norfolk North 2, Oak Lake Town 1, St. Boniface 1, St. Vital 1. (Late Reported: Winchester 2).

DIPHTHERIA: Total 16—Winnipeg 7, Kildonan 4, St. James 2, Gimli Village 1, The Pas Town 1, Tuxedo Town 1.

WHOOPING COUGH: Total 12—Winnipeg 5, Transcona 4, St. James 1, Flin Flon 1. (Late Reported: Flin Flon 1).

LOBAR PNEUMONIA: Total 10—Brandon 2, Ste. Anne 2, Hanover 1, La Broquerie 1, Ochre River 1, Wallace 1, Whitehead 1, Unorganized 1.

ERYSIPELAS: Total 6—Winnipeg 4, Melita Town 1, Westbourne 1.

ANTERIOR POLIOMYELITIS: Total 5—Gilbert Plains 1. (Late Reported: St. Andrews 2, Norfolk North 1, Brooklands Village 1).

INFLUENZA: Total 5—Winnipeg 2, Portage la Prairie City 1. (Late Reported: Dauphin Town 1, Portage la Prairie City 1).

BACILLARY DYSENTERY: Total 3— (Late Reported: Hanover 3).

ENCEPHALITIS: Total 2—Portage la Prairie Rural 1. (Late Reported: Unorganized 1).

TYPHOID FEVER: Total 2—(Late Reported: Selkirk 1, Unorganized 1).

SEPTIC SORE THROAT: Total 2—Brandon 1, Daly 1.

UNDULANT FEVER: Total 2—Winnipeg 1. (Late Reported: Portage la Prairie City 1).

MENINGOCOCCAL MENINGITIS: Total 1—Winnipeg 1.

TRACHOMA: Total 1—St. Clements 1.

DIPHTHERIA CARRIERS: Total 1—Winnipeg 1.

PARA TYPHOID B: Total 1—Cypress South 1.

VENEREAL DISEASE: Total 167—Gonorrhoea 96, Syphilis 71.

TREATY INDIANS: Total 17—Mumps 12, Tuberculosis 3, Diphtheria 1, Diphtheria Carriers 1.

DEATHS FROM COMMUNICABLE DISEASES

April, 1942

URBAN—Cancer 43, Tuberculosis 11, Pneumonia Lobar 5, Pneumonia (other forms) 10, Influenza 5, Diphtheria 2, Syphilis 2, Lethargic Encephalitis 1, Measles 1. Other deaths under 1 year 15. Other deaths over one year 201. Stillbirths 21. Total 317.

RURAL—Cancer 30, Pneumonia Lobar 2, Pneumonia (other forms) 17, Tuberculosis 11, Influenza 3, Measles 2, Diphtheria 1, Cerebrospinal Meningitis 1, Lethargic Encephalitis 1, Scarlet Fever 1, Syphilis 1, Typhoid Fever 1, Dysentery 1. Other deaths under one year 17. Other deaths over one year 187. Stillbirths 20. Total 296.

INDIANS—Tuberculosis 9, Pneumonia Lobar 1, Pneumonia (other forms) 7, Cancer 1, Influenza 1, Puerperal Septicæmia 1. Other deaths under one year 4. Other deaths over 1 year 8. Stillbirths. 0. Total 32.

DISEASES	Manitoba April 23 to May 20	Ontario April 19 to May 16	Saskatchewan April 19 to May 16	Minnesota April 19 to May 16	North Dakota April 19 to May 16
Amebic Dysentery	1			2	
Anterior Poliomyelitis	1		1	1	
Meningococcal Meningitis	1	30	1		
Chickenpox	128	881	134	323	
Diphtheria	16	5	14	8	7
Erysipelas	6	8	5	4	
Influenza	3	12	17	2	90
Leth. Encephalitis	1		3		2
Measles	589	739	67	3733	165
German Measles	26	243	51		
Mumps	352	1705	808		
Scarlet Fever	124	881	173	246	49
Septic Sore Throat	2	6			
Smallpox				1	
Trachoma	1		2		
Tuberculosis	52	223	31	40	60
Typhoid Fever		10		2	3
Typh. Para-Typhoid	1	3	10		
Undulant Fever	1	9	2		
Whooping Cough	11	365	1	148	40
Gonorrhoea	96	434			32
Syphilis	76	431			30

Manitoba is still having too much Diphtheria, note those sixteen cases and compare our population with that of Ontario and Minnesota. We still supply toxoid free,—how about it? Ontario had thirty cases of Meningococcal Meningitis reported. It is rather surprising that the incidence of this disease has not increased more during wartime. Measles, Mumps and Scarlet Fever are quite prevalent. Smallpox—one case in Minnesota.

Encephalitis and Poliomyelitis both show a few cases reported, in fact, at the time of writing (June 17, 1942) Manitoba has had eleven cases of Poliomyelitis reported in 1942 and eight cases of Encephalitis. The area between Haywood and Bruxelles has had two of these cases of Encephalitis and four of Poliomyelitis. It seems that the virus infection of both these diseases is widely distributed and we must be on the alert for outbreaks.

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